TESTIMONY

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OVERSIGHT OF CDC POLICIES AND DECISIONS DURING THE COVID-19 PANDEMIC

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RELEASE ONLY UPON DELIVERY

Chairman Wenstrup, Ranking Member Ruiz, and distinguished members of the Subcommittee, it is an honor to appear before you at my last Congressional hearing as CDC Director to reflect on CDC policies and decisions during the COVID-19 pandemic.

I began my tenure as CDC Director in January 2021 when the United States was in the depths of the COVID-19 pandemic, the deadliest in over a century. As a practicing infectious disease doctor who had been on the front lines treating patients with COVID-19, I recognized the enormity of the challenges facing CDC.

Thanks to significant investments and innovation, by January 2021, safe and effective COVID-19 vaccines had been developed in record time. The next step, supporting the administration of vaccines across the country, was also an historic undertaking. The United States did not have an established infrastructure to distribute and administer vaccines to adults. It was up to CDC, working closely with our public and private sector partners, to stand up this infrastructure to support safe, equitable, and efficient access for over 330 million Americans.

The COVID-19 pandemic also presented challenges with the collection and sharing of critical public health data. Access to timely, consistent, and quality data is instrumental in any public health response. We need accurate information on where and how quickly a disease is spreading so we can make the best decisions to protect our families, communities, and ourselves. However, the way in which public health data is currently collected and shared means that federal, state, and local leaders do not always have the information needed to understand the latest trends and make time-sensitive decisions to prevent further spread of disease, including COVID-19.

Throughout the COVID-19 pandemic, CDC continued to work to protect Americans from other dangerous and costly public health concerns, including mpox, malaria, vaccine-preventable diseases like polio and measles, and viral hemorrhagic fevers like Ebola. We do this work because a disease threat anywhere is a disease threat everywhere.

In the midst of these challenges and learning how to fight the novel COVID-19 pathogen amid evolving science, we were also faced with the critical challenge of getting kids back in school to prevent learning loss and support their well-being. In March 2020, state and local school officials began announcing school closures around the country in response to the growing spread of SARS-CoV-2. As a mother of three school and college-aged boys, I understood first-hand what being out of school was doing to our children. While chief of the division of infectious diseases at Massachusetts General Hospital, I directed

my team to create a publicly available COVID-19 School and Community Resource Library[1] for clinicians and public health experts advising schools and community groups on strategies to prevent and manage COVID-19, to help them safely reopen. In July 2020, I published a paper on best uses of testing to safely reopen institutes of higher education.

When I began my tenure as CDC Director in January 2021, only 46 percent of school districts in the United States were providing full-time in-person instruction. As we all recognize, schools provide critical services to students beyond education, including school meal programs and social, physical, behavioral, and mental health services. Based on data available from late 2020 and early 2021, we knew that schools could be opened safely with strict adherence to layered mitigation strategies, even while we waited for increased vaccine access. Building on the scientific evidence to provide guidance to state and local school officials on reopening schools was a key priority for me, among many urgent needs, as the incoming CDC Director.

COVID-19 Response – From Crisis to End of the Public Health Emergency

We are in a far different place with respect to COVID-19 than we were in January 2021. The federal COVID-19 public health emergency declaration expired on May 11, 2023. As a nation, we have mourned the loss of more than 1.1 million family members, neighbors, colleagues, and friends from COVID-19. And because of the work of this agency and public health and health care workers across the country in all of our communities, we have saved millions of lives.

Adult Vaccine Infrastructure

We know that the administration of safe and effective vaccines is one of the best public health measures to protect against severe disease and death from COVID-19. These results are thanks to an unprecedented public/private partnership, in which CDC built the infrastructure to rapidly deploy safe and effective vaccines to the entire U.S. population. Since December 2020, more than 676 million doses of a COVID-19 vaccine have been administered in the United States. Overall, as of May 10, 2023, over 230 million people in the United States have received their primary vaccine series and over 56 million people have received at least one updated (bivalent) vaccine dose. According to a study by the Commonwealth Fund conducted last year, COVID-19 vaccines had already saved more than 3.2 million lives in the United

[1] See covidlibrary.pdf (massgeneral.org)

States, prevented more than 18.5 million hospitalizations, and saved over $1.15 trillion in health care costs.[2]

Data

Data is the foundation of CDC's work, particularly in the context of a public health emergency response where critical decisions at the federal, state, tribal, local, and territorial community levels on where and how to target interventions and resources must be made quickly to ensure actions are effective and reach the most impacted populations. We have made great strides in our ability to collect real-time, high-quality information through our Data Modernization Initiative (DMI)—to update core data and surveillance infrastructure across the public health landscape and support health departments and health care providers. For example, before the COVID-19 pandemic, only 187 healthcare facilities were using Electronic Case Reporting (eCR) to send information to health departments. Following CDC support through DMI, as of May 2023, over 25,400 healthcare facilities in all 50 states are using eCR. Using eCR provides timely and more complete data than manual reporting and decreases the burden on both healthcare facilities and public health staff, facilitating disease tracking, case management, and contact tracing.

In April 2022, CDC, with the support of Congress, announced the launch of the new Center for Forecasting and Outbreak Analytics (CFA). CFA enhances the nation's ability to use data, models, and analytics to enable timely, effective decision-making in response to public health threats. CFA is building a world-class outbreak analytics team with experts across several disciplines to develop faster, richer evidence to predict trends and guide decision-making during emergencies. CFA also advances the state of the science of outbreak data, models, and analytics to improve the nation's ability to respond to health emergencies. Since being established, CFA has contributed to numerous ongoing response activities, including by leading development of four technical reports on the mpox outbreak. The reports provided timely updates on CDC's response and the trajectory of the outbreak. These reports were developed at the speed of the outbreak, to get the best information we had to decision makers quickly.

School Guidance

One of my top priorities as CDC Director was to help state and local school officials safely reopen schools. Three weeks after I became CDC Director, on February 12, 2021, CDC released the Operational

[2] Meagan C. Fitzpatrick et al., "Two Years of U.S. COVID-19 Vaccines Have Prevented Millions of Hospitalizations and Deaths," *To the Point* (blog), Commonwealth Fund, Dec. 13, 2022. https://doi.org/10.26099/whsf-fp90

Strategy for K-12 Schools through Phased Prevention (K-12 Operational Strategy), a roadmap to reopen schools for in-person instruction and help them remain open through consistent use of mitigation strategies. The guidance emphasized implementing layered prevention strategies based on community needs to protect students, teachers, and members of their households while getting kids back in the classroom. Evidence available at the time suggested that many K-12 schools that strictly implemented mitigation strategies were able to safely open for in-person instruction and remain open.

CDC's school recommendations, which are not and never have been requirements, are intended to provide broad guidance and serve as a foundation for local decision-making. CDC's K-12 Operational Strategy included a pathway to reopen *all* schools and help *all* schools remain open through consistent use of mitigation tools. For schools whose doors were already open, it provided recommended steps to stay open and to do so safely; and for those that were not yet operating in person, it provided a plan to inform swift and safe reopening.

But our work didn't end there. We continued to develop and follow the science. We added a component to layered mitigation strategy studies underway to measure the impact of distance between desks on infection rates. These were the first studies to document that secondary transmission was low in schools where students and teachers were consistently using masks, even when desks were less than 6 feet apart. At the same time, we published Morbidity and Mortality Weekly Reports (MMWRs) on risks associated with sports when mitigation strategies were not in place; and negative mental and emotional health experiences associated with virtual schooling. The day after these studies were published, CDC updated K–12 school guidance to reflect the latest science on physical distance between students in classrooms to reflect that with universal masking, students should maintain a distance of at least 3 feet in classroom settings.

By the end of the 2020-2021 school year, following CDC's release of the Operational Strategy for K-12 Schools, 63 percent of school districts were providing full-time in-person instruction, up from 46 percent at the start of my tenure in January 2021, and most others were offering partial in-person instruction. In August and September 2021, 99 percent of school districts began the school year offering full in-person instruction to all students. I was so pleased that my sons were among them.

Ongoing Response to Global Threats

As CDC responded to the largest public health emergency in its history, other emerging threats did not stop. In addition to COVID-19, CDC has been on the front lines of other pressing infectious disease outbreaks within the United States and around the globe. In May 2022, CDC confirmed the first domestic

case of mpox as part of a global outbreak and acted immediately to detect additional cases; educate clinicians and the public about a pathogen unknown to many that was transmitting in a novel way; and, support state and local public health responses. We engaged our Laboratory Response Network and commercial lab partners from the beginning to establish robust, accessible diagnostic testing capacity and worked hand-in-hand with our Department of Health and Human Services and state and local partners to distribute the JYNNEOS vaccine from the Strategic National Stockpile to protect persons at increased risk. Supply remains available and is not a primary barrier to increasing vaccine uptake.

In addition to addressing domestic health threats, CDC supports responses around the world including outbreaks of viral hemorrhagic fevers—Ebola (Sudan Ebola virus) in Uganda and the recent Marburg outbreaks in Equatorial Guinea and Tanzania.

On September 20, 2022, the Ugandan Ministry of Health confirmed an outbreak of Ebola (Sudan Ebola virus) in central Uganda. The United States government mobilized a whole-of-government interagency response, through U.S. Embassy Kampala, to support the Government of Uganda's response to the Ebola outbreak and minimize outbreak spread. CDC deployed multiple staff skilled in epidemiology, surveillance, laboratory, and ecology to Uganda, and worked in close collaboration with other U.S. government agencies, the Ugandan government, World Health Organization (WHO), and other partners to immediately respond to the threat. With our partners, we trained doctors, nurses, and community health workers, disease detectives and laboratorians. Together, we equipped laboratories and treatment centers. CDC's efforts with our partners ultimately helped extinguish the Ebola outbreak in under four months – an enormous accomplishment and relief, as there are currently no FDA-approved countermeasures for disease caused by the Sudan Ebola virus strain.

On February 13, 2023, the Equatoguinean Ministry of Health and Social Welfare confirmed an outbreak of Marburg Virus Disease (MVD), and on March 21, 2023, Tanzania's Ministry of Health confirmed a separate outbreak of MVD. Since these were the first documented cases in their respective countries, CDC worked closely with other U.S. agencies, the governments, WHO, and multilateral partners to supplement capacity on the ground. Within a week, CDC sent a team of experts to provide guidance, support, and training for surveillance, case investigation, contact tracing, and laboratory testing to Equatorial Guinea. In Tanzania, the CDC Country Office provided immediate support in epidemiology, surveillance, and data management. CDC continues to monitor trends in both countries. CDC's rapid response in both countries was crucial to protecting against the possible introduction and spread of this viral hemorrhagic disease into the United States and around the world.

Moving Forward

We have come a long way in addressing the COVID-19 emergency that strained our nation's public health system. As we emerge from this pandemic, CDC must address long-standing challenges if the agency is going to continue to lead the country in responding to these public health threats. Beginning in spring 2022, I launched an extensive review of the agency's organizational structures, systems, and processes to strengthen its ability to deliver on its core mission to equitably protect the health, safety, and security of Americans. In August 2022, based on this review and other substantial internal and external input, I launched the CDC Moving Forward initiative which focuses on the following top improvement areas:

- Share scientific findings and data faster
- Enhance laboratory science and quality
- Translate science into practical, easy to understand policy
- Prioritize public health communications
- Develop a workforce prepared for future emergencies—CDC and nationwide, and
- Promote results-based partnerships

On January 24, 2023, I announced a CDC reorganization, one of several foundational steps to achieve progress in the improvement areas outlined above. This reorganization aims to eliminate bureaucratic reporting layers, break down silos in the agency, promote foundational public health capabilities, and improve accountability at CDC.

Parallel to the reorganization, my leadership team has engaged staff from across the agency on priority actions that will improve how we do our work. This work is ongoing, but I'm proud to say that CDC has already implemented numerous actions, including:

- Improved efficiencies in scientific review by reducing clearance time for CDC publications by 50 percent;
- Initiated the CDC Infectious Disease Test Review Board, an internal group to promote quality assurance prior to national deployment of laboratory tests;
- Established process for institutions to submit applications for access to investigational drugs, reducing the time required for institutions to apply from 14 days to 6 hours—utilized with tecovirimat for mpox; and
- Implemented executive leader performance plan changes that outline expectations for CDC leaders in response participation, data modernization, and scientific quality and timeliness.

New Authorities

CDC has worked hard over the last two years to tackle internal challenges and build more resilient systems that can better respond and adapt to emergencies. But we also need support from Congress for revised and new authorities so that CDC can better respond to the next emerging disease. CDC has historically been forced to rely on time-consuming processes within our existing authorities and policies to meet operational and programmatic needs when time is of the utmost essence. The COVID-19 pandemic and other outbreaks have underscored how much these challenges have hampered the agency and continue to do so. These gaps must be addressed. In the FY 2024 Budget, we have requested legislative changes that are critical to the agency's ability to be more effective and responsive during fast moving, large-scale public health outbreaks. These proposals fall under two broad categories: 1) operational readiness and 2) strengthening workforce capacity. On their own, these proposals are not likely to be sufficient to change how CDC responds to the next emerging threat. However, taken together, they offer a roadmap to provide the tools and resources CDC needs to better prepare for, and respond to, the next emerging public health threat, whether from a local outbreak or a global pandemic. I have highlighted examples of two authorities below and we welcome continued discussion on ways to strengthen CDC to protect our national security through public health.

Data

Having timely, high-quality data on where diseases are spreading, the severity of illness, and the populations most impacted is a critical element of operational readiness. Timely data collection and reporting allow state and local public health professionals, health care providers, and policy makers to target interventions and resources to mitigate an outbreak and predict future spread. CDC's ability to generate national, aggregate data is critical for state and local health departments, providing them with national and regional contexts for their community's data. Disease does not stop at state or county lines, which is why it is so important that CDC be empowered to provide communities with situational awareness by ensuring timely reporting of the right information in a useful manner. These data also help build the scientific evidence base that is critical to understanding the gaps in our scientific knowledge and to helping identify and promote effective interventions. If CDC must continue to rely on a decentralized framework for data reporting, subject to a patchwork of individually negotiated Data Use Agreements, we will not be able to provide the best forecasts and modeling in the world, and we will not have complete information to share with our state and local partners in a timely way, hampering our partners' ability to make time-sensitive decisions to protect their communities.

Where we can, we are making improvements on sharing data. However, the way in which public health data are collected and shared has resulted in delayed, fragmented, and inconsistent reporting to CDC, and to state and local public health partners. To address this issue and support better data sharing with states,

localities, and providers, CDC will need a legislative change to modernize the public health data policy framework.

Vaccines For Adults

CDC built the public health infrastructure for adult vaccination during the COVID-19 pandemic. However, unless we are able to leverage and sustain the investments made to create this infrastructure, we will be in the same position we were in January 2020 the next time there is an outbreak of a vaccine-preventable disease. Establishing a robust infrastructure through a Vaccines for Adults program for uninsured persons, similar to what exists in the Vaccines for Children program will support response readiness by reducing vaccination coverage disparities, improving outbreak control of vaccine-preventable diseases, and enhancing the infrastructure needed for responding to future pandemics.

Conclusion

When I testified for the first time before this Subcommittee in April 2021, I noted that the United States had faced three significant emerging infectious disease threats in the decade prior to COVID-19—the H1N1 influenza pandemic, Ebola, and Zika. None of these emergencies resulted in the sustained improvements and investments needed in our nation's public health infrastructure, leaving us vulnerable in the face of the COVID-19 pandemic. We have come a long way since the beginning of the COVID-19 pandemic, but there is still much work to be done to ensure that CDC is ready to respond to the next public health threat. We must bolster our public health infrastructure by making sustainable investments and supporting new authorities that address long-standing vulnerabilities and better prepare us for the next public health challenge.

During my time at CDC, I had the true gift of meeting, working with, and giving voice to thousands of people who work 24/7 not only at CDC, but in your communities, to protect this nation from COVID-19 and other public health threats. I have never been prouder of anything I have done in my professional career.

Thank you, and I look forward to your questions.